

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10641

281

10641 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown				c. LENGTH OF STAY IN 1b 37 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Park Hall			
3. NAME OF DECEASED (Type or print) Louise				First Louise	Middle Edna	Last Cornwell	4. DATE OF DEATH Month October
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 1, 1880	9. AGE (In years less birthday) 70	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 1	Year Hours Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) New York		
13. FATHER'S NAME Charles Henry Sweeting				14. MOTHER'S MAIDEN NAME Mary Fife			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT James H. Cornwell		Address Park Hall, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] Pulmonary embolus Strangification of the heart Late - post clavicular sepsis							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 586X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Accident							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p.m. p.m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Auburn	(County) New York	(State) NY	
21. I certify that I attended the deceased from 8-28-56 , 19_____, to 10-1-56 , 19_____, that I last saw the deceased alive on 10-1-56 , 19_____, and that death occurred at 8:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Leonardtown, Maryland DATE SIGNED 10-1-56							
ACTUAL SIGNATURE Barbarich M.D.							
PHYSICIAN'S NAME (Type) Micheal Barbarich							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/4/56	22c. NAME OF CEMETERY OR CREMATORIAL Soule	22d. LOCATION (City, town, or county) Auburn	22e. (State) New York			
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland				24a. REC'D BY REGISTRAR Oct 5 1956	24b. REGISTRAR'S SIGNATURE W. Clarke Mattingley		

STATE OF CALIFORNIA

CERTIFICATE OF DEATH

RECEIVED

SURVEY

OCT 5 1956

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10642

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE New York		b. COUNTY Essex		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River		c. LENGTH OF STAY IN 1b 6 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keeeseville (Port Kent)				
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Naval Air Station Hospital, Station				d. STREET ADDRESS South Sable		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Rosemary		First	Middle	Last	4. DATE OF DEATH DAGUE	Month October	Day 29	Year 19 56
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1930	9. AGE (In years lost birthday) 26 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Judson LONZO				14. MOTHER'S MAIDEN NAME Edith Campbell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Station, Hospital, Addressee, U. S. Naval Records,				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pre-eclampsia DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Oct 28, 1956, to Oct 29, 1956, that I last saw the deceased alive on Oct 29, 1956, and that death occurred at 2:14 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>J. Orlando</i> M.D. 10-29-56. PHYSICIAN'S NAME (Type) R. ORLANDI, LT MC USNR								
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 10/31/56		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) (State) Keeeseville, New York		
23. FUNERAL DIRECTOR'S SIGNATURE <i>O.B. Robinson</i>				24a. REC'D BY REGISTRAR DATE 11/1/56		24b. REGISTRAR'S SIGNATURE <i>Gloria Hauser</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF STATE - BUREAU OF INTELLIGENCE

CERTIFICATE OF DATA

SEARCHED	INDEXED
SERIALIZED	FILED
NOV 2 1956	
FBI - LOS ANGELES	
RECEIVED	

BUREAU OF INVESTIGATION
NOV 2 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10643

10643

CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH a. COUNTY ST. MARYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		b. COUNTY ST. MARYS	
c. LENGTH OF STAY IN 1b ST. MARYS HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. MARYS HOSPITAL		d. STREET ADDRESS RURAL	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CATHERINE DELORIS FENWICK	First	Middle	Last
4. DATE OF DEATH OCTOBER 19 1956	Month	Day	Year
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 9, 1916
			9. AGE (In years last birthday) 39 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAID		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EUGENE BARNES		14. MOTHER'S MAIDEN NAME ANNIE C. EDISON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ALLEN C. FENWICK, LEXINGTON PARK, Md.	
17. INFORMANT ANNIE C. EDISON		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage DUE TO 330X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 7 hours 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 19, 1956 to Oct 19, 1956 that I last saw the deceased alive on Oct 19, 1956 , and that death occurred at 8:30 AM from the causes and on the date stated above. ACTUAL SIGNATURE Wm H. Patrick MD PHYSICIAN'S NAME (Type) Wm H. PATRICK MD Lexington Park Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/23/56	
22c. NAME OF CEMETERY OR CREMATORIUM HOLY FACE CEMETERY		22d. LOCATION (City, town, or county) GREAT MILLS MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Johnson		ADDRESS LEONARDTOWN, Md.	
24a. REC'D BY REGISTRAR 10-23-56		24b. REGISTRAR'S SIGNATURE Glen D. Hauser	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 24 1956

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10644
Reg. Dist. No. 282

10644

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mechanicsville		c. LENGTH OF STAY IN 1b 30 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Veronica	Middle Harper	4. DATE OF DEATH October 24, 1956
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William S. Lyles		14. MOTHER'S MAIDEN NAME Martha Ann King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Reginald Harper Mechanicsville, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. p. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____		DATE, 1956, to Oct., 1956, that I last saw the deceased ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Leon W. Bemby		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/27/56	22c. NAME OF CEMETERY OR CREMATORIAL St Joseph's	22d. LOCATION (City, town, or county) Morganza, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE 10/26/56		24b. REGISTRAR'S SIGNATURE Glenda D. Hansen	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CEMETRIE OF DATA

WYKŁADZIENIA STOSOWANIA KOMPUTERÓW W GEOFIZYCE - PREZENTACJA

BUREAU Y.

OCT 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10645

Reg. Dist. No.

281

10645

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE Maryland b. COUNTY St. Mary's	
Rural St. George Island Life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Edward	Middle D.	Last Henderson	4. DATE OF DEATH October 20, 1956
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1894	9. AGE (in years 61 yrs.) IF UNDER 1 YEAR Months 10 Days 8 IF UNDER 24 HRS. Hours Min.
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Henderson		14. MOTHER'S MAIDEN NAME Anna E. Rice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Edward D. Henderson St. George Island,	
(If yes, give war or dates of service) None					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 850X DUE TO <i>Drowning (Accidental)</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell overboard from boat</i>			
20c. TIME OF INJURY Month, Day, Year <i>Labour a.m. Oct 20 1956</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <i>St George Island</i> 20f. (City or town) <i>St George Island</i> (County) <i>Hanover Co.</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>P.J. Bean M.D.</i>		DATE SIGNED <i>Oct 22/56</i>			
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/23/56</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St George Island</i> 22d. LOCATION (City, town, or county) <i>St George Island, Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Clarke Mattingley</i>		ADDRESS <i>Leonardtown, Md.</i>		24a. REC'D BY REGISTRAR <i>Methodist</i> DATE <i>10/23/56</i> 24b. REGISTRAR'S SIGNATURE <i>P.J. Bean M.D. Registration</i>	

BUREAU V. S.
RECEIVED
OCT 25 1966

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10646

10646

CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND			2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital			d. STREET ADDRESS Box 676 RFD 1		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Elizabeth	Middle Margaret	Last Hughes	4. DATE OF DEATH Month October Day 24, Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH Nov. 14, 1890	9. AGE (In years and birthday) yrs. 65	10. IF UNDER 1 YEAR Months 0 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Gruebler			14. MOTHER'S MAIDEN NAME Margaret Moser		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs W.H.Kirby Address Lexington Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - INTERVAL BETWEEN ONSET AND DEATH 420.1					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b)		DUE TO Cardiac failure -			
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Leonardtown Md.	
21. I certify that I attended the deceased from Oct 10, 1956 to Oct 24, 1956 that I last saw the deceased alive on Oct 24, 1956 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Charles Greenwell M.D. ADDRESS (Street, city or town, state) Leonardtown Md. DATE SIGNED					
PHYSICIAN'S NAME (Type)		Charles Greenwell M.D. Leonardtown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/56		22c. NAME OF CEMETERY OR CREMATORIAL New Cathedral	
22d. LOCATION (City, town, or county) Baltimore, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Kenny Funeral Home		ADDRESS Daltimore, Md.		24a. REC'D BY REGISTRAR T. C. Hausey DATE 10/29/1956	
VS A15 (4) 15M 9/35		24b. REGISTRAR'S SIGNATURE A. Hausey			

BUREAU V. S.

OCT 1955

REGISTRATION

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-510M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10647

10647

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	St. Marys	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland	COUNTY St. Marys	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Leonardtown		TOWN Great Mills	STREET ADDRESS	(If rural give location)
St. Marys Hospital			Rural		
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
(First) JOHN TONY JUROVATY			10 / 27 / 1956		
(Middle)			(Day)		
(Last)			(Year)		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months Days Hours Min
male	white	married	Nov. 20, 1893	62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Blacksmith		Civil Service		Czechoslovakia	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Paul Jurovaty			Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO		17. INFORMANT & ADDRESS	
(If Yes, give war or dates of service)				Mrs. Charles Catron- Great Mills, Md.	
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN ANTECEDENT CAUSE(S) DUE TO <u>General arterial sclerosis</u> ONSET AND DEATH DISEASES OR CONDITIONS, IF ANY, (B) <u>5 years</u> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO STATING UNDERLYING CAUSE LAST. (C)					
3 days					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>October 27, 1956</u> , to <u>October 27, 1956</u> , that I last saw the deceased alive on <u>October 27, 1956</u> , and that death occurred at <u>130pm</u> , from the causes and on the date stated above. SIGNATURE <u>P. J. Bean</u> ADDRESS (Street, city, town, state) <u>Great Mills, Maryland</u> DATE SIGNED <u>10-27-56</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIUM	
Burial		10/30/58		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
DATE 10-30-56		Pyman, Md.		ADDRESS	
O.B. Robinson - Leonardtown, Md.					

LAU Y. L.

1500

LAU Y. L.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10648

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown	c. LENGTH OF STAY IN 1b 29 Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Washington	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George	First Middle Morgan	Knight Jr.	4. DATE OF DEATH October 4, 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH July 10, 1908
8. AGED (in years last birthday) yrs. 48		9. IF UNDER 1 YEAR Months 2	10. IF UNDER 24 HRS. Days 24
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Journalist		10b. KIND OF BUSINESS OR INDUSTRY News Paper	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Morgan Knight Sr.		14. MOTHER'S MAIDEN NAME Grace Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT None Mrs Grace W. Knight Leonardtown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/5 1956 to 10/5 1956, that I last saw the deceased alive on 10/5 1956, and that death occurred at 11 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles Greenwell M.D.		ADDRESS (Street, city or town, state) Leonardtown Maryland DATE SIGNED	
PHYSICIAN'S NAME (Type) Charles Greenwell M.D.		Leonardtown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/56	
22c. NAME OF CEMETERY OR CREMATORIAL St. Andrew's		22d. LOCATION (City, town, or county) (State) Leonardtown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 10-8-56	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

OCT 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10649

CERTIFICATE OF DEATH

Reg. Dist. No. 2

10649

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		c. LENGTH OF STAY IN 1b Eight Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Solomons Annex, USNAS, Patuxent River, Md.		d. STREET ADDRESS Quarters 234		
d. NAME OF HOSPITAL, MEDICAL CENTER, CLINIC, OR INSTITUTION STATION HOSPITAL, USNAS, PATUXENT RIVER, MARYLAND						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Robert		First	Middle	Last	4. DATE OF DEATH PECK	Month	Day	Year
5. SEX Male		6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) February 4, 1926 30 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aviator		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corp		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Jesse Oren PECK		14. MOTHER'S MAIDEN NAME Deceased Phoebe Allen		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 12-6-43		17. INFORMANT U.S. Naval Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries, multiple, extreme		
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.		(b)		(c)		DUE TO		
DUE TO		(b)		(c)		INTERVAL BETWEEN ONSET AND DEATH Immediate		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pilot of plane, crashed and burned, USNAS, PATUXENT RIVER, MD.						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1200 Noon Oct. 2 1956		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Service Test		20f. (City or town) USNAS, PATUXENT RIVER, MD.		(County) (State)
21. I certify that I attended the deceased from Oct 2 , 1956, to Oct 2 , 1956, that I last saw the deceased alive on Oct 2 , 1956, and that death occurred at 1200N M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 		DATE SIGNED 10-2-56
ACTUAL SIGNATURE J. L. Brockman		PHYSICIAN'S NAME (Type) J. L. BROCKMAN, LT MC USNR		STATION HOSPITAL USNAS, PATUXENT RIVER, MARYLAND				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/56		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Arlington, Va.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Johnson		ADDRESS Conardtown, Md.		24a. REC'D BY REGISTRAR 10/5/56		24b. REGISTRAR'S SIGNATURE Glenn D. House		

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-tranish permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

18 AUGUST

1956



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10650

10650 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within **1** hour after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park Rural		c. LENGTH OF STAY IN 1b 5 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	
		Rural Lexington Park d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph Aloysius Price		First Middle	4. DATE OF DEATH Month Day Year October 1 1956
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1942 9. AGE (in years last birthday) 14 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Francis Price	
14. MOTHER'S MAIDEN NAME Mary Agnes Kelly		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Address George Francis Price, Lexington Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Inmed.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Backed over by automobile	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Lexington Park	(County) St. Mary's	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) J. Roy Guyther	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED 10/2/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/4/1956	22c. NAME OF CEMETERY OR CREMATORIUM St. Aloysius	22d. LOCATION (City, town, or county) Leonardtown
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley, Leonardtown, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE 10/5/56	24b. REGISTRAR'S SIGNATURE

A 22-1

Oct 5 1956

Angus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10651

10651

CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH a. COUNTY St Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY St Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood Rural		c. LENGTH OF STAY IN 1b 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle M.	Last Russell	4. DATE OF DEATH	Month October	Day 6,	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 26, 1878	9. AGE (In years from birth) 77 yrs.	IF UNDER 1 YEAR Months 9	IF UNDER 24 HRS. Days 10	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. Lemuel Russell		14. MOTHER'S MAIDEN NAME Nellie Gibson		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)	
						<i>Coronary Thrombosis</i> <i>Senility</i>	
						INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
				20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/23 , 19 26 , to 10/5 , 19 56 , that I last saw the deceased alive on 10/5 , 19 56 , and that death occurred at 11:30 AM, from the causes and on the date stated above.		ACTUAL TIME		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) Charles Greenwell		M.D.		<i>Leonardtown</i>		<i>Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/56		22c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart		22d. LOCATION (City, town, or county) Bushwood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Nattingley		ADDRESS Leonardtown, Maryland		24a. REC'D BY REGISTRAR 10-8-56		24b. REGISTRAR'S SIGNATURE Glen D. Hauser	

TO HOSPITAL: _____ may be referred to the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LEADER

OCT 9 1956

LEADER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10652

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Pennsylvania		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsburgh		d. STREET ADDRESS 7743 Kelly			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mortimer		First P.	Middle Sullivan	Last L.	4. DATE OF DEATH October 7, 1956	Month October	Day 7	Year 1956	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1879	9. AGE (in years last birthday) 77 yrs	10. UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Firemen		10b. KIND OF BUSINESS OR INDUSTRY City Fire Dept.		11. BIRTHPLACE (State or foreign country) Wales, England		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jeremiah Sullivan		14. MOTHER'S MAIDEN NAME Norah Grace							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Agnes G. Sullivan 7743 Kelly St. Pittsburgh, Penna.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (b)		Pneumonia & heart attack Cardio - rено - vascular syndrome				INTERVAL BETWEEN ONSET AND DEATH			
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Sept 3, 1956 , to Oct 7, 1956 , that I last saw the deceased alive on Oct 7, 1956 , and that death occurred at 610 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE Barbarich		M.D.							
PHYSICIAN'S NAME (Type) Michael Barbarich M.D.		Leonardtown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/56		22c. NAME OF CEMETERY OR CREMATORIUM St. Augustine		22d. LOCATION (City, town, or county) Millville, Penna.			
23. FUNERAL DIRECTOR'S SIGNATURE John Kekilty		ADDRESS 605 Bruston Ave. Pittsburgh Penns.		24a. REC'D BY REGISTRAR Glantz L. Haider		24b. REGISTRAR'S SIGNATURE			
VS A15 (4) 15M 9/55				DATE 10-8-56					

RECEIVED
FEB 1956

OCT 9 1956

FEDERAL BUREAU OF INVESTIGATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10653

10653

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 3 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bushwood		d. STREET ADDRESS Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Philip	Middle Alexander	Last Tyer	4. DATE OF DEATH Month October	Day 8,	Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 1, 1903	9. AGE (In years last birthday) yrs. 51	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Joseph Tyer				14. MOTHER'S MAIDEN NAME Elizabeth Shore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		None		Catherine Tyer		Bushwood, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial insuff. INTERVAL BETWEEN ONSET AND DEATH 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) acute urin. reten.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2 Oct 1956 to 8 Oct 1956					
20c. TIME OF INJURY Hour a. p. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 8 Oct 1956	(County)	(State)	
21. I certify that I attended the deceased from 8 Oct 1956 to 8 Oct 1956 , that I last saw the deceased alive on 8 Oct 1956 , and that death occurred at 8 Oct 1956 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Maryland							
ACTUAL SIGNATURE Leon A. Berube	DATE SIGNED Leon A. Berube M.D.						
PHYSICIAN'S NAME (Type) Leon Berube M.D.	Mechanicsville, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/11/56	22c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart	22d. LOCATION (City, town, or county) Bushwood, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		ADDRESS	24a. REC'D BY REGISTRAR 10-10-56		24b. REGISTRAR'S SIGNATURE Leon O. Hansen		

27. JUNO: MEET JUPITER - GRAVITATIONAL STATE OF THE PLANET

BUREAU V. 3

OCT 11 1956

REGELY ED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10654
10654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 282
1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown			c. LENGTH OF STAY IN lb 6 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Mills			d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First William	Middle Alard	Last Ward	4. DATE OF DEATH October 5, 1956		Month October	Day 5	Year 1956	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1952	9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Bascom Ward					14. MOTHER'S MAIDEN NAME Bertha Johnson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address W. Bascom Ward Great Mills, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock, secondary to Lemon lage DUE TO Compound fracture, skull INTERVAL BETWEEN ONSET AND DEATH 6 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 812X DUE TO Compounded fracture, skull (c) Compounded fracture, skull										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by automobile							
20c. TIME OF INJURY Hour 5 p.m.		Month, Day, Year Oct 5 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Great Mills, St. Mary's Md.		(County) St. Mary's	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>J. Roy Guyther</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								DATE SIGNED 10/15/56
EXAMINER'S NAME (Type) J. Roy Guyther M.D.		22d. LOCATION (City, town, or county) Valley Lee, Maryland (State) Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/56		22c. NAME OF CEMETERY OR CREMATORIAL St George's		24a. REC'D BY REGISTRAR DATE 10-8-56				24b. REGISTRAR'S SIGNATURE <i>Glen O. Danner</i>
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		ADDRESS								

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

OCT 9 1956

RECEIVED